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## Our legal responsibility ... to intervene on behalf of the child' : recognising public responsibilities for the medical treatment of children

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**‘Our legal responsibility ... to intervene on behalf of the child’<sup>1</sup>: recognising public responsibilities for the medical treatment of children**  
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**Abstract**

This article argues for recognition of public responsibilities to protect the welfare of children with respect to decisions affecting their health and medical treatment. As the quote in the title of this article, from David Plank, the Director of Social Services responsible for bringing the case of Baby Alexandra before the courts, identifies, early cases concerning children’s medical treatment were brought by local authorities to determine responsibilities to protect the welfare of children. In cases such as *Re B* (1981), *Re J* (1990), and *Re W* (1992) the court was asked not only to determine the child’s best interests but also to clarify the duties of the local authority, Trust, court, and child’s parents to the child. The respective duties established apply to all involved in cases brought before the courts on the question of a child’s future medical treatment, whether or not the child is in the care of the state. Recent cases concerning the medical treatment of seriously ill children have involved claims of parental authority to determine the care of their child. To the contrary, this article argues that court involvement is required when parents are disagreed with the child’s treating doctors over the child’s medical treatment because of public as well as parental and professional responsibilities for the welfare of all children.

**Introduction: Reflecting on over four decades of Case Law**

The invitation to deliver the 2019 Annual Public Lecture of the Health Law Regulation Unit and European Children’s Rights Unit a quarter of a century after I started my academic career in the Liverpool Law School prompted me to reflect back on my subject, the legal regulation of the provision of medical treatment to children. Reviewing the body of case law over the past forty years, I observed that in a significant number of the early cases and in cases throughout the body of case law, local authorities were involved either because the child was in local authority care, or because the child’s doctors had sought the advice of the local authority given the latter’s child protection duties. That led me to reflect upon cases concerned with a child’s health or medical treatment from the perspective of public responsibilities for the care, and protection of the welfare, of children. This is recognised in the title of my lecture and this article, which starts with a quote from David Plank, who was Director of Social Services responsible for bringing the case of Baby Alexandra before the court in 1981,<sup>2</sup> both of whom I return to below.

This article first examines the initial cases brought before the courts by a local authority which required the courts to determine the duties of parents, local authorities, doctors and the courts and established the protective role of the court when issues of a child’s health or medical treatment are before it. It then explains the allocation of responsibilities between parents, local authorities, and the court by the Children Act 1989 which provides the framework for children’s medical treatment cases as well as for child law more generally. The respective responsibilities are then considered in the cases concerned with older children in local authority care who have refused medical

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<sup>1</sup> Janet Read and Luke Clements, ‘Demonstrably Awful: The Right to Life and the Selective Non-Treatment of Disabled Babies and Young Children’ (2004) 31 JLS 482-509, 501 quoting David Plank, personal interview. This article is a written version of the 2019 Annual Public Lecture of the Health Law and Regulation Unit and European Children’s Rights Unit. My thanks to Amel Alghrani and Helen Stalford for the invitation, the audience for their questions and comments and the anonymous reviewers for their comments on an earlier draft.

<sup>2</sup> *Re B (a minor) (wardship: medical treatment)* [1981] 1 WLR 1421.

treatment; parental refusal due to their religious beliefs; termination of a child's pregnancy; immunisation of children in care; and, the participation of the local authority in cases of withdrawal or withholding of life-sustaining treatment from children with life-limiting conditions. It argues that the involvement of the public authorities – the local authority bringing cases into the public realm of the court – resulted from and led to identification of public responsibilities. The doctor/patient relationship and the cases which arise due to disagreements about medical treatment or health are matters of private law and decisions about a child's medical treatment are ordinarily private decisions made together by parents and doctors but, this article demonstrates, they also involve public responsibilities for the welfare and protection of children. Further, whilst the involvement of the court provides an important protective role in respect of children in the care of the state, it is argued that this is equally its role – public responsibility for the protection of the welfare of the child - in disputes between parents and doctors about a child's medical treatment.<sup>3</sup>

### **The First Reported Cases: bringing decisions into the public domain**

The first reported case in which the decision of the child's parent and doctor was referred to court, *Re D* in 1976, concerned non-therapeutic sterilisation rather than the medical treatment of a child.<sup>4</sup> As Heilbron J observed the case involved 'entirely novel circumstances' for a wardship application. However, the judge considered that wardship was appropriate, as she could not 'conceive of a more important step' than the proposed non-consensual non-therapeutic sterilisation of the child.<sup>5</sup> Furthermore, the case raised a 'matter of principle of considerable public importance'.<sup>6</sup> Before the court, the consultant paediatrician claimed that the decision was a matter for clinical judgement as long there was consent from the parent. Heilbron J responded that the reasons given for sterilising D were both clinical and social which meant that the decision was not solely a matter of medical expertise. On the facts, the judge concluded that the sterilisation operation was not necessary, medically indicated, nor in D's best interests<sup>7</sup> and declined to authorise the operation.<sup>8</sup> The case established the role of the court, placing the welfare of the child as the paramount consideration,<sup>9</sup> in the determination of the issue referred to it, not by the child's parent or doctor, but by the local education authority given that others involved in D's care had formed a different view about her best interests. The decision whether D should undergo a sterilisation operation was not a private matter for her mother and paediatrician, others had caring responsibilities to her which, when they profoundly disagreed with the

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<sup>3</sup> The balance of responsibilities between parents, doctors, local authorities, and the court in the law governing children's medical treatment is examined in Jo Bridgeman, *Medical Treatment of Children and the Law: Beyond Parental Responsibilities*, Routledge, 2020.

<sup>4</sup> *Re D (a minor) (wardship: sterilisation)* [1976] Fam 185.

<sup>5</sup> *Re D* [1976] Fam 185, 196.

<sup>6</sup> *Re D* [1976] Fam 185, 187.

<sup>7</sup> *Re D* [1976] Fam 185, 196. Helen Stalford has explained that best interests is 'universally regarded as a central tenet of children's rights', 'The broader relevance of children's rights law: The "best interests of the child" principle' in *Children's Rights Law in the Global Human Rights Landscape: Isolation, Inspiration, Integration?*, E. Brems et al. (eds), 2017, 37-51. This was demonstrated by the Children's Rights Judgments Project of the European Children's Rights Unit in their rewritten judgments concerning Family Life, Medical Decision-making, Public Authorities, Criminal Justice and International Children's Rights, in *Rewriting Children's Rights Judgments: From Academic Vision to New Practice*, Helen Stalford et al, (eds), Bloomsbury Publishing, 2017.

<sup>8</sup> *Re D* [1976] Fam 185, 194.

<sup>9</sup> *Re D* [1976] Fam 185, 194.

decision, gave them a legitimate interest in seeking an independent determination of the court in the exercise of its protective jurisdiction to children.

In the 1981 case of *Baby Alexandra, Re B*,<sup>10</sup> the health authority sought the advice of the local authority when Alexandra's parents refused their consent to surgery to remove an intestinal blockage given their view that, as she had Down's Syndrome, she would not enjoy a quality of life. Against the background of the prosecution of Dr Arthur following the death of John Pearson whom he had instructed should be given 'nursing care only' after his parents rejected him because he had Down's Syndrome,<sup>11</sup> the local authority applied to court to clarify the legal obligations of doctors, parents, and social services in relation to decisions concerning the medical treatment of a child. Upon the application of the local authority, Ewbank J made Alexandra a ward of court and gave the local authority care and control so that it could give consent to the operation. However, the surgeon at the hospital to which Alexandra had been moved for the surgery declined to operate given the refusal of her parents. The local authority brought the matter back before Ewbank J who determined that the wishes of the parents should be respected despite the surgeon at the hospital where she had been born being prepared to carry out the operation. That conclusion supported the view that this was a private decision to be reached by parents together with doctors. However, the local authority appealed. The Court of Appeal emphasised that, as the issue had been brought before the court in wardship proceedings, it was the duty of the court to determine whether surgery was in Alexandra's best interests. Brought to court by the local authority uncertain of the applicable legal obligations, the court exercised its independent duty to determine the welfare of the child and authorised the procedure.<sup>12</sup> Through the intervention of the local authority and the decision of the court, public responsibilities for the protection of the welfare of the child were fulfilled.

In their article on the withholding of life-sustaining treatment from babies with disabilities, Janet Reid and Luke Clements quoted David Plank, the Director of Social Services for the local authority in *Re B*, who had said to them in an interview:

'We decided that clearly it was right that the baby should have the operation because the baby was an independent person and had a right to life ... It was our legal responsibility as a social services authority to intervene on behalf of the child ... [T]he arguments that were being made against having the operation, basically did not distinguish between the parents and the child and saw the child wholly as a possession of the parents. And in law, that's not right and morally that's not right.'<sup>13</sup>

Janet Reid and Luke Clements observed that the case resulted in unprecedented 'public interrogation' of medical practice and of decisions which had previously been

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<sup>10</sup> *Re B (a minor) (wardship: medical treatment)* [1981] 1 WLR 1421.

<sup>11</sup> *R v Arthur* (1981) 12 BMLR 1. Anne Morris observed that *R v Arthur* had drawn public attention to the practice of withholding treatment from children with disabilities, Anne Morris, 'Selective treatment of irreversibly impaired infants: Decision-making at the threshold' (2009) 17 Medical Law Review 347–376, 348.

<sup>12</sup> Michael Freeman reported that Alexandra was temporarily taken into care in the exercise of the local authority's protective duties to the child, although a few months later she was returned to the care of her parents, *The Rights and Wrongs of Children*. London: Pinter, 1983, 262.

<sup>13</sup> Janet Reid and Luke Clements, 'Demonstrably Awful: The Right to Life and the Selective Non-Treatment of Disabled Babies and Young Children' (2004) 31 JLS 482–509, 501.

reached privately between parents and doctors.<sup>14</sup> The decision of the court established that it was not lawful for parents and doctors to leave a child to die just because that child had disabilities.<sup>15</sup> But, furthermore, the importance of *Re B* together with *Re D* for debates about the role of law in regulating medical practice and the responsibilities of parents, professionals, and public authorities with regard to children cannot be overstated. The cases demonstrated the responsibilities of doctors to seek the advice of local authorities, the responsibility of the local authority to intervene and, where necessary to protect the welfare and interests of the child, to refer the question to court and for the court to exercise its protective jurisdiction in determination of the welfare of the child. Whilst these cases involve personal decisions concerning dependent children, they are a matter of public concern as they raise fundamental questions about the value of life and public as well as private responsibilities to vulnerable children who are unable to articulate their own interests. The framework within which these responsibilities were to be exercised was then provided by the Children Act 1989.

### **The Children Act 1989: framing the responsibilities of parents, public authorities and the State**

The Children Act 1989 is central to the legal framework for decision-making about children's medical treatment.<sup>16</sup> Following review by the Law Commission of private law and a government review of public law concerning children,<sup>17</sup> the Children Act 1989 created a comprehensive legislative framework bringing together public and private law concerning the care, protection, and upbringing of children. It provides a coherent set of legal concepts and principles across child welfare in the resolution of disputes concerning children, support services for children in need, and compulsory powers for child protection. Nigel Parton, writing in 1991, argued that the Children Act was concerned with 'constructing a new consensus' or 'a new set of balances related to the respective roles and responsibilities of the state and the family in the upbringing of children'.<sup>18</sup>

Issues of children's medical treatment were clearly envisaged as coming within the scope of the Children Act 1989. Decisions about a child's medical treatment are made in the exercise of parental responsibility,<sup>19</sup> a concept introduced by the Act. The concept encapsulates both that parents have responsibilities to their children rather than rights over them and that children are primarily the responsibility of their parents,

<sup>14</sup> Janet Read and Luke Clements, 'Demonstrably Awful: The Right to Life and the Selective Non-Treatment of Disabled Babies and Young Children' (2004) 31 JLS 482-509, 501.

<sup>15</sup> Jonathan Herring, '*Re B (A Minor) (Wardship: Medical Treatment)*'; "The Child Must Live": Disability, Parents and the Law' in *Landmark Cases in Medical Law*, Jonathan Herring and Jesse Wall (eds), Hart, 2015, 63-81, 66.

<sup>16</sup> Detailed more fully in Jo Bridgeman, *Medical Treatment of Children and the Law: Beyond Parental Responsibilities*, Routledge, 2020, ch. 2.

<sup>17</sup> There were four Law Commission working papers on child law: *Review of Child Law: Guardianship* (Law Com No 91, 1985); *Review of Child Law: Custody* (Law Com No 96, 1986); *Review of Child Law: Care, Supervision and Interim Orders in Custody Proceedings* (Law Com No 100, 1987); *Review of Child Law: Wards of Court* (Law Com No 101, 1987) informing the recommendations in its report, Law Commission, *Review of Child Law: Guardianship and Custody* (Law Com No 172, 1988) which provide the basis for the private law provisions. The Department of Health and Social Security, *Review of Child Care Law. Report to Ministers of an Interdepartmental Working Party* (HMSO, 1985) and White Paper, *The Law on Child Care and Family Services* (Cm 62, 1987) inform the public law provisions.

<sup>18</sup> Nigel Parton, *Governing the Family: Child Care, Child Protection and the State*, Macmillan, 1991, 148.

<sup>19</sup> *Re A* [2001] Fam 147, 178.

not the state.<sup>20</sup> The role of the state is to support parents to fulfil their responsibilities to their children.

Different opinions about a child's upbringing held by those with parental responsibility or with an interest in the child's welfare<sup>21</sup> can be referred to court for the court to determine in a Specific Issue Order or Prohibited Steps Order.<sup>22</sup> Decisions about a child's medical treatment can also be referred to court in an application for the court to exercise its inherent jurisdiction, although local authorities require leave to make an application. In either application the welfare of the child is the paramount consideration; the Welfare Checklist applies to orders under the Children Act.<sup>23</sup>

Whilst the Specific Issue Order and Prohibited Steps Order fall within the private law provisions of the Act, the public law provisions of the Children Act also form part of the framework within which parents, professionals, public authorities, and the courts fulfil their duties to children. The Children Act sets out compulsory powers for child protection which are founded upon a division of responsibilities between the local authority and the court.<sup>24</sup> Only a local authority can initiate proceedings by asking the court in a fact finding hearing to determine whether the threshold set out in s.31(2) has been satisfied,<sup>25</sup> only then can a court make an order according to its judgement of the welfare of the child. The Children Act requires NHS Trusts to assist a local authority which is making enquiries to decide whether any action should be taken to safeguard or protect the child's welfare by providing relevant information and advice if asked to do so.<sup>26</sup> The statutory obligations imposed by the Children Act 1989, the Children Act 2004, and professional duties require a doctor to act on any concerns that the welfare of a child is at risk of harm from the care given by their parent by informing the designated doctor for child protection or seeking the advice of the safeguarding team.<sup>27</sup> This may, in appropriate circumstances, result in the Trust applying to court for an order in relation to a child's medical treatment or seeking the advice of the local authority which may undertake enquiries under s.47. Child protection proceedings will be appropriate when parental behaviour threatens significant harm to the child. This may be because the child's parents have been unable to care for their child,<sup>28</sup> because the parents lack capacity to exercise parental responsibility,<sup>29</sup> or where there are

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<sup>20</sup> John Eekelaar, 'Parental responsibility: State of nature or nature of the state?' (1991) 13 JSWFL 37-50.

<sup>21</sup> Law Commission, *Review of Child Law: Guardianship and Custody*, No.172, 1988, 4.41. Such as a Trust on behalf of treating doctors in relation to an issue concerning a child's medical treatment.

<sup>22</sup> Children Act 1989, s.8.

<sup>23</sup> Children Act 1989, s.1.(3).

<sup>24</sup> Children Act 1989, Part IV.

<sup>25</sup> s.31(2) of the Children Act 1989 provides that: 'A court may only make a care order or supervision order if it is satisfied - (a) that the child concerned is suffering, or is likely to suffer, significant harm; and (b) that the harm, or likelihood of harm, is attributable to - (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or (ii) the child's being beyond parental control.'

<sup>26</sup> Children Act 1989, the persons listed in s.47(11) are any local authority, any local housing authority, the National Health Service Commissioning Board; any clinical commissioning group, Local Health Board, Special Health Authority, National Health Service trust or NHS foundation trust and any person authorised by the Secretary of State for the purposes of this section.

<sup>27</sup> GMC, *Protecting Children and Young People: the responsibilities of all doctors* (2012) <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people> [accessed 18 May 2020].

<sup>28</sup> *Re J* [1991] Fam 33.

<sup>29</sup> *In re Jake* [2015] EWHC 2442.

concerns that the quality of care provided presents the risk of causing the child significant harm because, for example, the child's parent has ignored or acted contrary to medical advice.<sup>30</sup> Importantly for the consideration of the case law which follows, when the court has made a care order, the local authority gains parental responsibility for the child which it shares with the child's parents,<sup>31</sup> giving the authority sufficient interest in decisions about a child's medical treatment to intervene.

The Children Act 2004, s.11, placed a duty on public services including NHS Trusts and Foundation Trusts to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children. As MacDonald J stated in the recent case of *Tafida Raqeeb*, when there is a disagreement between parents and doctors as to a child's best interests which cannot otherwise be resolved, this requires the Trust to apply to court for the issue to be determined. MacDonald J explained that to fail to do so would 'leave a void in relation to consent' contrary to its duties to the child. It would also 'confer[...] on the parents an unimpeachable authority to make welfare decisions in respect of their children notwithstanding countervailing medical advice, which is not the position in law'.<sup>32</sup>

Parents, doctors, local authorities, and the courts therefore have responsibilities with regard to children's medical treatment. Parents have primary responsibility for their children and must make decisions about their child's medical treatment, from the options available, according to their judgement of the child's best interests. Doctors have professional duties to act in the best interests of the child, to work in partnership with parents and, where all attempts to reach an agreement have failed, to refer questions about a child's medical treatment to court.<sup>33</sup> They have a statutory duty to work together with the local authority to assist it to fulfil its statutory obligations. When a question is referred to court by someone with an interest in the case, the duty of the judge is to decide according to the best interests of the child.

When the Children Act was passed, gaining Royal Assent in November 1989, there were a limited number of cases on a limited range of issues concerning the medical treatment of a child. The reported cases concerned with issues of a child's medical treatment or health were *Gillick*,<sup>34</sup> the judicial review cases of *Walker* (1987) and *Collier* (1988);<sup>35</sup> *Re B* (1981);<sup>36</sup> cases concerned with proposals to sterilise girls with learning difficulties;<sup>37</sup> termination of pregnancy;<sup>38</sup> and *Re C* concerned the withholding of life-sustaining treatment from a baby who had been made ward of court at birth.<sup>39</sup> Apart

<sup>30</sup> *In the Matter of E (A Child)* [2018] EWCA Civ 550, [107] as in *Westminster City Council v M and F and H* [2017] EWHC 518.

<sup>31</sup> Children Act 1989, s.33(3) and may where necessary to safeguard or promote the child's welfare, determine the extent to which the child's parent, or other holders of parental responsibility are able to exercise parental responsibility with respect to the child.

<sup>32</sup> *Tafida Raqeeb (by her Litigation Friend) v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) & *Barts NHS Foundation Trust v Shalina Begum and Muhamed Raqeeb & Tafida Raqeeb (by her Children's Guardian)* [2019] EWHC 2530 (Fam), [109].

<sup>33</sup> The legal and professional duties of doctors to children in their care are explored in Jo Bridgeman, *Medical Treatment of Children and the Law: Beyond Parental Responsibilities*, Routledge, 2020, ch. 4.

<sup>34</sup> *Gillick v West Norfolk and Wisbech Area Health Authority and another* [1986] AC 112.

<sup>35</sup> *R v Central Birmingham Health Authority, ex parte Walker* 3 BMLR 32; *R v Central Birmingham Health Authority ex parte Collier* [1988] 1 WLUK 690.

<sup>36</sup> *Re B* [1981] 1 WLR 1421.

<sup>37</sup> *Re D* [1976] Fam 185; *Re B* [1987] 2 WLR 1213; *Re M* [1988] 2 FLR 497.

<sup>38</sup> *Re G-U* [1984] FLR 811; *Re P* [1986] 1 FLR 272.

<sup>39</sup> *Re C* [1989] 3 WLR 240.

from *Gillick* (which involved a hypothetical question concerning the provision of contraception) and the judicial review cases, in all other reported cases the child concerned was either in local authority care,<sup>40</sup> or the application was made by the local authority for the child to be made a ward of court for the decision to be made by the court.<sup>41</sup> The next section analyses the cases which followed, adopting the approach which had been established in the small number of cases before the Children Act 1989 within the framework provided by the legislation in each example considering the initial case law and its application in more recent cases.

## **Local Authority Involvement in the Leading Cases of Children's Medical Treatment**

### *Refusal of Consent by Older Children*

Two cases, *Re R*,<sup>42</sup> decided shortly before the Children Act 1989 came into force, and *Re W*,<sup>43</sup> soon after, were both formative in the case law concerning children's medical decision-making. These cases have been, and continue to be, subjected to much academic critique,<sup>44</sup> from a variety of perspectives but the principles remain applicable, most recently applied to authorise the administration of blood to 15-year old X who was refusing given her beliefs as a Jehovah's Witness. What has not been considered, and is a crucial aspect, which I argue influenced the approach of the court in *Re R* and *Re W*, is that both were applications by the local authority with respect to children in local authority care, raising questions about the duties of the local authority, with parental rights or sharing parental responsibility, and the powers of the court with respect to vulnerable young women.

The facts of both cases are well known. However, some of the detail is forgotten behind academic debates about the extent to which they involved a retreat from *Gillick*,<sup>45</sup> their effect upon respect for the autonomy of teenagers and the ability of mature minors to refuse consent to recommended treatment. *Re R* was the first reported case concerned with the powers of the court in wardship with respect to the refusal of consent by a child to recommended medical treatment. Social services had been involved in the care of 15 year-old R for over 12 years. R had poor, and sometimes violent, parental relationships and difficulties establishing boundaries. She had been on the 'at risk' register as a possible victim of emotional abuse, in voluntary care, in a children's home under a place of safety order, cared for under an Interim Care Order and had been admitted under s.2 of the Mental Health Act 1983. At the time of the application she was in an adolescent psychiatric unit specialising in disturbance problems in young people. In short, social services had been involved in the care of R for much of her life. R was refusing to take medication to control her psychotic episodes. Those responsible for her treatment were concerned that, without medication, the psychotic episodes would return and there was a risk she may commit suicide. Social services were of the view that the local authority could not agree to the administration of anti-psychotic medication against her will.

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<sup>40</sup> *Re G-U* [1984] FLR 811; *Re P* [1986] 1 FLR 272; *Re B* [1987] 2 WLR 1213.

<sup>41</sup> *Re D* [1976] Fam 185; *Re B* [1981] 1 WLR 1421; *Re M* [1988] 2 FLR 497. *Re C* [1989] 3 WLR 240 had been made a ward of court at birth.

<sup>42</sup> *Re R* [1992] 1 FLR 190.

<sup>43</sup> *In Re W* [1993] Fam 64.

<sup>44</sup> Including, J Murphy, 'W(h)ither adolescent autonomy?' [1992] JSWFL 529; J Bridgeman, 'Old Enough to Know Best?' (1993) 13 Legal Studies 69; N Lowe and S Juss, 'Medical Treatment - pragmatism and the search for principle' (1993) 56 MLR 865; R Thornton, 'Minors and Medical Treatment - Who Decides?' [1993] CLJ 34; J Eekelaar, 'White Coats or Flak Jackets? Doctors, Children and the Courts - Again' (1993) 109 LQR 182.

<sup>45</sup> Gillian Douglas, 'The Retreat from *Gillick*' (1992) 55 MLR 569-576.



W had been in foster care for over 7 years, following the death of her father and then her mother. Her aunt, her testamentary guardian, had been unable to care for W, her sister, and brother. The children were placed into temporary foster care before being moved to permanent foster care where W was bullied. The children were moved to a new foster home but the foster mother required treatment for cancer. W's grandfather died. Shortly afterwards, W developed anorexia nervosa. At the time of the application by the local authority to court, W was being cared for in a specialist residential unit for children and adolescents but continued to lose weight and the issue was whether she should, contrary to her wishes, be moved to a specialist treatment centre for anorexia.<sup>46</sup> The effect of the judgments in *Re R* and *Re W* taken together, that a refusal to consent to recommended medical treatment by a child, whether *Gillick* competent or not, could be overridden by consent given by any holder of parental responsibility, including the local authority, or the court, was thus reached in the context of two vulnerable children in the care of the state. For different reasons and in different circumstances, neither R's parents nor W's guardian were able to provide the care each required, or support and guide them as they developed their independence. The approach of the judges to the welfare principle, that ordinarily it is in the welfare of the child for their wishes to be given weight but that there comes a point at which it is necessary to override those wishes given the other factors in the welfare checklist, was thus adopted in relation to teenagers who had had very difficult childhoods and lacked parental figures to guide and support them. The overriding responsibility of the judge was to secure the welfare of the child in the exercise of a public duty to protect the vulnerable.

These cases are formative as the judgments give guidance, specifically sought by the Official Solicitor in *Re R*, on the powers of the courts and, obiter, those with parental responsibility which was applied in the stream of cases that followed in the 1990s to much critical commentary.<sup>47</sup> However, these cases were concerned with the protective exercise of the powers of the court, at the request of the local authority, a holder of parental rights or responsibilities and with caring responsibilities with respect to vulnerable young people who had had extremely difficult childhoods and were now in the care of the state. On the facts, this understandably led to the conclusion that the child should be given the treatment recommended by doctors in the exercise of their professional judgement as necessary to avert significant and permanent harm or death. By referring the issue to court, decisions about the provision of medical treatment contrary to the wishes of the child in the care of the state were made publicly ensuring that the decisions could be subject to scrutiny and debate. In my judgement, it is not the outcomes of these two cases that is problematic, the judges exercising their protective jurisdiction in respect of two troubled teenagers in the care of the state and at risk of death could not have been expected to conclude that refusal of the conventional treatment for their condition was in their best interests. As Sir James Munby emphasised in *Re X* the argument that developments including the Human Rights Act 1998 mean that the position in *Re R* and *Re W* permitting the invasion of the autonomy of a *Gillick* competent child no longer 'reflects the law' needs to be given

<sup>46</sup> The application by the local authority for the court to exercise its inherent jurisdiction required the judge to be satisfied that if it did not do so, there was reasonable cause to believe that she was likely to suffer significant harm', s.100(3) and (4).

<sup>47</sup> Including Margaret Brazier and Caroline Bridge, 'Coercion or caring: analysing adolescent autonomy' (1996) 16 Legal Studies 84-109; Freeman, M. "Rethinking *Gillick*", *International Journal of Children's Rights* 2005 (13), 201-217; A Morris, 'Gillick, 20 years on: arrested development or growing pains?' (2005) PN 158; J Bridgeman, 'Because we care? The Medical Treatment of Children' in *Feminist Perspectives on Health Care Law*, S Sheldon & M Thomson (eds) (1998); R Huxtable, '*Re M (Medical Treatment: Consent)* Time to remove the 'flax jacket'? (2000) 12 CFLQ 83; C Bridge, 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 MLR 585.

proper attention.<sup>48</sup> As Margaret Brazier and Caroline Bridge have argued, the cases of *Re R* and *Re W* are distinguishable from those involving refusals by competent teenagers on the basis that defects in their reasoning meant that they did not have the capacity to refuse consent.<sup>49</sup> However, in all cases the law must continue to ensure the protection of the welfare of vulnerable children.

#### *Inability to Consent to Administration of Blood*

There was also a flurry of cases in the 1990s concerned with the question whether it was in the best interests of a child whose parents were Jehovah's Witnesses to have a blood transfusion. *Re R*,<sup>50</sup> *Re S*,<sup>51</sup> and *Re O*<sup>52</sup> were also concerned with determining the responsibilities of doctors, local authorities, and the courts when genuinely held parental beliefs as to their child's best interests presented, in the view of the child's doctors as demonstrated by their evidence to the court, a risk of causing the child significant harm. This was because parental refusal of consent to the administration of blood to a seriously ill child was preventing the administration of treatment recommended by the treating doctors and in their clinical judgement putting the child at risk of death. Booth J, in *Re R*, considered that the local authority had rightly applied for leave for a Specific Issue Order permitting the administration of blood to 10 month-old R who was being treated for B-cell lymphoblastic leukaemia. The evidence was that without the administration of blood R's treatment would not be successful. The local authority in *Re S* sought leave for the court to exercise its inherent jurisdiction and make an order permitting the transfusion of blood to S, a 4 year-old child receiving treatment for T-cell leukaemia. S's consultant paediatrician believed that S's condition had deteriorated so that palliative care was the only alternative to conventional treatment which required the administration of blood. In *Re O*, the application was likewise brought to court by the local authority, O's consultant having sought the advice of the local authority at the point he thought a transfusion was immediately necessary for O who had respiratory distress syndrome.<sup>53</sup> In each case, the opinion of the treating doctor that without the administration of blood the child was at risk of significant harm had prompted their inquiry of the local authority and the local authority application to court.

Whilst applications in such cases are now made by the NHS Trust,<sup>54</sup> rather than the local authority, the approach of court was established in these early cases. The administration of blood will be authorised if the situation is imminently life-threatening, in other circumstances requiring consultation with the child's parents permitting the administration of blood if there is no reasonable alternative. A reasonable alternative must surely be one that can be administered to the child in fulfilment of the doctor's legal duties to identify a treatment option that is supported by a competent body of professional opinion. Under the current legal framework, the legal issue in these cases is not whether the religious views of the parents should be respected. The child is an independent legal person and once the question of the administration of blood to the child is before the court, the legal duty of the judge is to make an independent assessment of the child's best interests, in these cases of children who were too young

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<sup>48</sup> *Re X (A Child)* [2020] EWHC 3003 [8], [19].

<sup>49</sup> Brazier M and Bridge C, 'Coercion or caring: analysing adolescent autonomy' (1996) 16 *Legal Studies* 84, 93-96.

<sup>50</sup> *Re R* [1993] 2 FLR 757.

<sup>51</sup> *Re S* [1993] 1 FLR 376.

<sup>52</sup> *Re O* [1993] 2 FLR 149.

<sup>53</sup> *Re O* [1993] 2 FLR 149, 155.

<sup>54</sup> Eg *Birmingham Children's NHS Trust v B and C* [2014] EWHC 531; *Cardiff and Vale University Health Board v T and H* [2019] EWHC 1671; *An NHS Trust v CX* [2019] EWHC 3033.

to have accepted their parents' beliefs or to have formed their own.<sup>55</sup> It is not the responsibility of judges to assess the reasonableness of parental views, whether it is religious or other beliefs that determine parental decisions about their child's medical treatment. Parents are free to raise their children according to the tenets of their religion but when decisions about a child's medical treatment are before the court, whilst the judge will consider the views of the child's parents, the duty of the judge is to make an independent determination of the best interests of the child on the basis of the evidence.

### *Termination of Pregnancy*

There are few reported cases concerning the termination of a child's pregnancy, although those that have been reported are located at both ends of the body of case law concerning children's medical treatment. They demonstrate the local authority, Trust, and the court working together to protect the welfare of the child. In *Re B*, the local authority applied for 12 year-old B to be made a ward of court having been informed of her pregnancy by her GP. The termination was authorised by two registered medical practitioners in accordance with the Abortion Act 1967. Whilst B wanted the pregnancy to be terminated, a decision of the court was sought given her age and the objection of her mother to the termination.<sup>56</sup> Parental objection to the termination prompted the local authority application to court for a declaration on the legality of the termination of the pregnancy of 15 year-old Shirley in *Re P*.<sup>57</sup> Shirley had been committed to the care of the local authority under the Children and Young Persons Act 1969 following her conviction for theft. Whilst in care she had become pregnant and was caring for her son in a mother and child unit. Pregnant for a second time, Shirley had decided that the pregnancy should be terminated as she would not be able to care for both children in the unit. Her father opposed this offering to care for her son so that Shirley could care for the new baby. The local authority applied for her to be made a ward of court which directed the termination in accordance with her decision and the medical view that a termination was lawful under the provisions of the Abortion Act 1967. Butler-Sloss J noted that although the local authority had, by virtue of the 1969 Act, the rights and obligations of a parent to a child in their care it had sought the authority of the court as it did not want to override the view of her father.<sup>58</sup> The judge considered this to be an appropriate case in which to assume jurisdiction and gave the doctors authority to perform the procedure without otherwise interfering with the powers of the local authority with respect to her care.<sup>59</sup> The decision of the court on the specific issue of the termination protected Shirley's decision and the local authority and doctors who agreed with it from legal challenge by Shirley's father.

Whilst the pregnancy of a young teenager will require that consideration is given to child protection issues, the approach of the courts in the cases on the termination of the pregnancy of a child has been that protection of her wishes, formed and maintained after discussion with supportive adults, protects her best interests. In *The matter of X (a child)*,<sup>60</sup> care proceedings had commenced with respect to 13 year-old X, described

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<sup>55</sup> Sir James Munby noted in *Re X (A Child)* [2020] EWHC 3003 the inevitable tension between the duty of the court and the established beliefs of a *Gillick* competent child [3] given that the duty of the court, without debating the merits of religious views and taking into consideration the views of a competent child, is to reach the judges own determination of what is in the best interests of the child when there is clear evidence of a serious risk to health or to life [12], [13].

<sup>56</sup> *Re B* [1991] 2 FLR 426.

<sup>57</sup> *Re P* [1986] 1 FLR 272.

<sup>58</sup> *Re P* [1986] 1 FLR 272, 274. After the Children Act 1989, the local authority application would have had to be under s.100(3) for the court to exercise its inherent jurisdiction.

<sup>59</sup> *Re P* [1986] 1 FLR 272, 276.

<sup>60</sup> *In the matter of X (a child)* [2014] EWHC 1871.

by the consultant clinical psychologist as a 'very damaged and impaired young girl', who lacked the capacity to make the decision. At the start of proceedings X was opposed to a termination. As a consequence the expert evidence was that a termination would not be in her best interests. During the course of the proceedings, X changed her mind. As Kirsty Moreton has observed, the unanimous view of the experts that termination was not in X's best interests was followed by the determination of the court that it was following her expression during the hearing of a wish to terminate the pregnancy.<sup>61</sup> The judge emphasised that, whilst X lacked the capacity to consent, she needed to indicate her views and through her words and actions demonstrate that she was 'compliant' and 'accepting'. Munby P made the declaration that the termination would be lawful as in X's best interests as long as X, after discussing the termination with her social worker and step-mother, continued for two days to express a wish to terminate the pregnancy. Child protection issues were to be dealt with in care proceedings and the question whether any criminal offences had been committed were for the police. Whilst the jurisdiction of the court is a protective one, in the application brought by the Trust, the sole issue was the specific one of the legality of terminating the pregnancy of a 13 year-old who lacked the capacity to give consent. Likewise, the application by the Trust in *An NHS Trust v A, B, C and A Local Authority*,<sup>62</sup> was made in circumstances where it was not certain whether 13 year-old A had the capacity to consent to the termination but if she did to reassure the doctors of the lawfulness of performing the termination. Mostyn J concluded that A had sufficient understanding and intelligence to make the decision.<sup>63</sup> The judge noted that there had been meetings with the Trust's safeguarding team and that, should A decide to continue with the pregnancy, she would require considerable support from both her family and social services. The limited case law on the termination of a pregnancy thus demonstrate local authorities and Trusts working together to protect the interests of vulnerable young women and girls. The decisions of the courts in these cases recognise that the termination of pregnancy is an issue upon which people have different opinions and their own decisions will be influenced by their current circumstances. The courts will protect the decisions of young girls in relation to the termination of a pregnancy, as long as termination is lawful in accordance with the Abortion Act 1967, ensuring that their wishes are determinative whether or not they have capacity but seeking to ensure that the decision is an established one formed through discussion with supportive adults. Wider concerns about the welfare of a young girl who has become pregnant are addressed by the local authority and, if appropriate, the court in child protection proceedings.

#### *Immunisation: Enabling Public Care*

The law on the issue of immunisation was framed by disputes between parents but King LJ suggested in the recent Court of Appeal judgment in *Re H* that it might be time to reconsider the approach of the courts to the issue of immunisation in private law disputes between parents as had the court in that case with respect to cases brought before the courts by the local authority.<sup>64</sup> In *Re H*, the Court of Appeal upheld the

<sup>61</sup> Kirsty Moreton, 'Gillick reinstated: judging mid-childhood competence in healthcare law' (2015) 23 *Medical Law Review* 303, 310.

<sup>62</sup> *In An NHS Trust v A, B, C and A Local Authority* [2014] EWHC 1445.

<sup>63</sup> Kirsty Moreton welcomed the 'determinative' approach to competence whilst arguing that the Mental Capacity Act 2005 should be applied to people of all ages and argued for a more relational approach to decision-making, 'Gillick reinstated: judging mid-childhood competence in healthcare law' (2015) 23 *Medical Law Review* 303.

<sup>64</sup> *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664. The earlier private law cases are *Re W (A Child)* [2000] 3 WLUK 200; *Re C and F (Children)* [2003] EWHC 1376 upheld on appeal *B (Child)* [2003] EWCA Civ 1148; *F v F (MMR Vaccine)* [2013] EWHC 2683; *In the Matter of M and N* [2016] EWFC 69 and unusually *In the Matter of M and N (no 2)* [2017] EWFC 49 upon the application of the Guardian

decision of Hayden J in the court below made against the background of a history of contested proceedings with regard to the care of T and contrary to the earlier case of *Re SL*,<sup>65</sup> that the local authority could authorise routine vaccinations within the scope of s.33(3) of the Children Act 1989. When a care order is made with respect to a child, the local authority gains parental responsibility by virtue of s.33(3)(a) and the power to determine the extent to which other holders of parental responsibility may meet that responsibility which the local authority must do in accordance with their overarching duty to protect and safeguard the welfare of the child.<sup>66</sup> Hayden J had followed earlier case law in distinguishing vaccination from medical treatment as a 'facet of public preventative healthcare intending to protect both individual children and society more generally' and thus appropriately a matter for parents in the exercise of their parental responsibility rather than a decision for the State.<sup>67</sup> King LJ considered that preventative healthcare and medical treatment overlapped but that the distinction was that, where there are no contra-indications to vaccination in relation to the child in question, the vaccination of children in accordance with Public Health England's guidance, *The Green Book: Information for public health professionals on immunisations* was not a 'grave' issue.<sup>68</sup> This conclusion was based upon a review of the medical evidence on the risks of contracting each disease, the nature of the illness, and the risks of side-effects from the vaccination. The judge reviewed the MMR controversy observing that it was concerns about the safety of the MMR vaccine which had led to concerns about the safety of vaccines more generally, had resulted in the involvement of the court in both private and public law cases, and continued to be at root of parental objection to vaccination.<sup>69</sup> The evidence led her Ladyship to conclude that the study by Dr Andrew Wakefield, published in *The Lancet* in 1998, which claimed there was a link between the MMR vaccine and autism and had led to a fall in rates of

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who wished the order to be enforced, the order was varied to remove the requirement for vaccination whilst the declaration that it was in the children's best interests remained; *Re B (A Child: Immunisation)* [2018] EWFC 56; Two cases had been brought by local authorities *Re A, B, C and D (Welfare of Children: Immunisation)* [2011] EWHC 4033 and *Re SL (Permission to vaccinate)* [2017] EWHC 125.

<sup>65</sup> *Re SL (Permission to vaccinate)* [2017] EWHC 125, [32]-[33], In which MacDonald J held that, because of the gravity of the issue, s.33 did not give the local authority power to consent to vaccination overriding parental objection but that the local authority should apply to the court for a declaration in the exercise of the court's inherent jurisdiction.

<sup>66</sup> Children Act 1989, ss.33(3)(b) & 33(4). Subsections 6-8 places limits upon the local authority's exercise of parental responsibility so that it may not change a child's religion, agree to adoption, appoint a guardian, change the child's surname without written agreement or (without going through prescribed procedures) remove the child from the United Kingdom for more than a month without written agreement

<sup>67</sup> *London Borough of Tower Hamlets v M & F & T* [2020] EWHC 220 [12] following *B (Child)* [2003] EWCA Civ 1148 [22], rather than non-essential invasive treatment; *Re B (A Child: Immunisation)* [2018] EWFC 56 [2].

<sup>68</sup> *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664, [85]. On the facts, Hayden J made the declarations given that the history of proceedings left him in no doubt that if the local authority had sought to have T vaccinated in the exercise of their parental responsibility T's parents would have applied for the court to exercise its inherent jurisdiction.

<sup>69</sup> *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664, [42]-[54]. Sumner J noted the MMR litigation in *Re C and F (Children)* [2003] EWHC 1376, [22]; *F v F (MMR Vaccine)* [2013] EWHC 2683 was specifically concerned with the MMR vaccine, the parents having agreed that L should not have the booster and M should not have the vaccine after the Wakefield paper. The father made the application concerned about the potentially serious consequences of contracting the diseases given that Wakefield's study had been discredited and prompted by the then recent outbreak of measles in Wales, [3]-[4].

MMR vaccination and an increased questioning of the safety of the vaccination programme more generally had been discredited by 2010. Subsequent studies had found no evidence of a link between MMR and autism. Her Ladyship expressed the view that, absent new peer-reviewed research evidence indicating significant concern about the efficacy and/or safety of one of the recommended vaccines, objections to vaccination based on general concerns about efficacy or safety would be unlikely to be upheld.<sup>70</sup> Absent evidence of a specific vaccine being contraindicated for a particular child, the medical evidence was that vaccination in accordance with the recommended schedule was in the best interests of the child and with those exceptions the courts had, in all cases, authorised vaccination.<sup>71</sup>

*Re H* held that the decision to consent to routine vaccination came within the general duties of the local authority to safeguard and promote the welfare of looked after children.<sup>72</sup> This enabled local authorities to fulfil their public responsibility to protect the welfare of children in their care informed by the prevailing view that immunisation is in the welfare of all children<sup>73</sup> and particularly those whose upbringing has otherwise been chaotic or neglectful. In *Re H* the local authority had taken over T's care to provide him with,

‘a safe, consistent and emotionally stable family environment free from the risks posed by neglect, addiction and exposure to domestic violence in order to thrive and develop to fulfil his potential. It is important that he has equitable access to all aspects of child health including vaccination against preventable illnesses, health promotion, and monitoring of his growth and development’.<sup>74</sup>

King LJ posed the question whether vaccination should remain within that small group of cases in private law to which all holders of parental responsibility must be agreed or an order of the court is required. Removal of vaccination from the group of issues requiring the agreement of all with parental responsibility or a decision of the court will not prevent all future cases, as with other issues in relation to the upbringing of a child upon which holders of parental responsibility are unable to agree, a SIO or PSO order could still be sought to resolve private law disputes over vaccination. However, the case of *Re H* means that the approach to the welfare of the child in cases that are before the courts could not be clearer. As MacDonald J subsequently observed in *M v H & P & T*, the consequence is that it is ‘very difficult now to foresee’ that vaccination would not be considered to be in a child’s best interests unless there was new medical or research evidence or a specific contraindication for a particular vaccine in relation to an individual child.<sup>75</sup> On the issue of vaccinations, public and private law has developed in step, demonstrating the need for a better appreciation of the relationship between public and private responsibilities for the welfare of children.

#### *Withholding or Withdrawal of Life-sustaining Treatment*

The need for analysis of the relationship between public and private responsibilities for the welfare of children is also evident with regard to the law governing the withholding

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<sup>70</sup> *Re H (A Child) (Parental Responsibility: Vaccination)* [2020] EWCA Civ 664, [55].

<sup>71</sup> Those cases in fn 64. In *Re C and F (Children)* [2003] EWHC 1376, vaccinations against whooping cough and Hib were not age appropriate for 12 year-old F nor vaccinations against tuberculosis or tubercular meningitis for 4 year-old C.

<sup>72</sup> Children Act 1989, s.22(3)(a).

<sup>73</sup> Richard Huxtable has argued that immunisation is a public health measure so that the welfare of the individual child may not be the appropriate focus, ‘*Re C (A Child) (Immunisation: Parental Rights)* [2003] EWCA Civ 1148’ (2004) 26 Journal of Social Welfare and Family Law 69-77.

<sup>74</sup> *London Borough of Tower Hamlets v M & F & T* [2020] EWHC 220, [30].

<sup>75</sup> *M v H & P & T* [2020] EWFC 93, [52].

or withdrawal of life-sustaining treatment from children with life-limiting conditions. The initial cases, in which the courts established the legal principles governing these cases, were referred to court by local authorities. The courts have also addressed the scope of s.33 of the Children Act 1989, the exercise of parental responsibility by parents and the local authority, and the role of the court in relation to decisions to withhold or withdraw life-sustaining treatment from children in care. And, I argue, in the concluding section below, that the public responsibilities evident in cases in which the local authority has responsibility for the care of children have framed the approach of the court to all cases of treatment decisions concerning children with life-limiting conditions.

In *Re C* and *Re J* (1991) the court noted the lack of guidance for those required to make decisions about the provision of life-sustaining treatment to children. In both cases, the child had been made a ward of court, whilst the local authority retained 'care and control' over the child. Neither child had left hospital since birth. Court involvement was inevitable; as a ward, all major decisions about the child's upbringing had to be made by the court. In *Re C*, Balcombe LJ highlighted the lack of guidance from the legislature for courts or others – parents, professionals, local authorities - in such cases.<sup>76</sup> The responsibility of the judge, his Lordship emphasised, was to undertake a best interests analysis. The purpose of the judgment of the court was to explain clearly the reasons for the decision of the court and the course of treatment to be administered to a baby in the care of the state ensuring that the decision could be subjected to scrutiny and the issues raised examined in wider debate.

In *Re J* (1991), the following year, Lord Donaldson noted that the Official Solicitor had asked for guidance on 'the generality of the problem' and sought to assist those who have to make such decisions by offering some clarification.<sup>77</sup> When the decision was before the court, in wardship, the judge was to give paramount importance to the best interests of the child in determination of which there is a 'very strong presumption in favour of a course of action which will prolong life' and taking into account the pain and suffering caused by the treatment and the quality of life which the child will experience if life is prolonged, from the assumed point of view of the child.<sup>78</sup> But that 'intolerability' was not, as had been submitted to the court, a 'quasi-statutory yardstick'.<sup>79</sup>

Further, Lord Donaldson MR distinguished the duties of parents, doctors, and court. Whilst parents and the court, which 'takes over the rights and duties of the parents', must give consent to a child's medical treatment according to their judgement of best interests, the legal duty of the doctor is to care for the child according to 'good medical practice recognised as appropriate by a competent body of professional opinion'.<sup>80</sup> In ideal circumstances, doctors, parents, and when involved, the court work together in partnership to secure the course of action that is in the best interests of the child. Whilst parents and the court must determine the child's best interests neither parents nor the court can require doctors to administer treatment that is 'medically contra-indicated' or which they could not 'conscientiously administer'. *Re J* (1991), together with the second *Re J* (1993) over which Lord Donaldson also presided and in which he affirmed those principles,<sup>81</sup> have had a profound and enduring effect upon the

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<sup>76</sup> *Re C (a minor) (wardship: medical treatment)* [1990] Fam 26, 38.

<sup>77</sup> *Re J (a minor) (wardship: medical treatment)* [1991] Fam 33, 47.

<sup>78</sup> *Re J* [1991] Fam 33, 46.

<sup>79</sup> *Re J* [1991] Fam 33, 46.

<sup>80</sup> *Re J* [1991] Fam 33, 41 quoting *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

<sup>81</sup> *Re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15

principles and approach of the courts in children's decision-making cases.<sup>82</sup> Determined in wardship proceedings with the consequence that the responsibility of the judge was to undertake a best interests analysis, decisions about the future medical treatment of both children were brought before the courts by local authorities who had legal and caring responsibilities to them. It was important that these cases were brought before the court not just to reassure the children's doctors that to withhold life-sustaining treatment would not amount to a civil wrong or criminal offence but more importantly, as Lord Donaldson MR had observed in *Re C*, given the public interest in decisions to limit treatment to a vulnerable child in the care of the state.

A further issue concerns the respective responsibilities, within s.33 of the Children Act 1989, of the local authority, parents, doctors, and the court in relation to decisions to limit life-sustaining treatment to children in care. Given the profound and enduring consequences of such decisions, decisions about withholding or withdrawal of life-sustaining treatment from a child in care come within the category of decisions to which all with parental responsibility must agree or a court order is required. In *Kirklees Council v RE and Others*,<sup>83</sup> the local authority made an application for a declaration that it was not in SE's best interests to receive further life-sustaining treatment and in his best interests to receive palliative care. SE had lung, heart and kidney conditions. An Interim Care Order had been made soon after his birth. Although, as he had remained in hospital since his premature birth, he had not been able to live with his foster carers they spent time with him daily at the hospital. The application was supported by the Trust, by SE's Guardian, and his mother accepted the medical opinion as she did not want him to suffer. Moor J agreed with Counsel for the local authority that an application had to be made to court in cases where 'there is parental opposition, parental equivocation or doubt as to parental capacity to decide'.<sup>84</sup> Whilst the local authority had parental responsibility for the child by virtue of the ICO, to protect the interests of the child and ensure that the views of the parent were properly taken into consideration on such a grave matter, it was necessary to bring the matter before the court.

Where the child's parents lack the capacity to decide about life-limiting treatment a decision of the court is required as consent cannot be provided by all with parental responsibility. In *Re Jake* the local authority shared parental responsibility with the parents of ten month-old Jake under an Interim Care Order. Both parents had a diagnosed learning disability. His father had the capacity to litigate whilst his mother did not.<sup>85</sup> Jake's parents and the local authority agreed with his doctors that, in the event of a deterioration in his condition, Jake should be given palliative care. As Munby P observed, the local authority had encouraged the Trust to apply for the court to exercise its inherent jurisdiction on the basis that it was 'not appropriate' for the local authority alone to consent to the withholding of life-sustaining treatment.<sup>86</sup> Sir James Munby P emphasised the importance of facilitating the involvement of parents who lack capacity to make decisions about their child's future medical care. The President stressed that the parents must be involved, told what was happening, and what was being proposed.<sup>87</sup> The views, wishes, and feelings of the parents who 'faced with this

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<sup>82</sup> Providing the basis for the legal principles applied in contemporary cases eg *GOSH v Yates & Gard* [2017] EWHC 972, [38]-[41].

<sup>83</sup> *Kirklees Council v RE and Others* [2014] EWHC 3182.

<sup>84</sup> *Kirklees Council v RE and Others* [2014] EWHC 3182, [20].

<sup>85</sup> *Re Jake* [2015] EWHC 2442, [3].

<sup>86</sup> *Re Jake* [2015] EWHC 2442, [48].

<sup>87</sup> *Re Jake* [2015] EWHC 2442, [46].



dreadful situation, very much understand the fundamental dilemmas and the fundamental problems' had to be taken into account.<sup>88</sup>

The decision to withhold or withdraw life-sustaining treatment from a child is as profound a decision as is possible to be made in the exercise of parental responsibility. When the child is not in the care of the local authority, the child's treating doctors would be acting lawfully if they withdrew or withheld life-sustaining medical treatment upon the consent of one holder of parental responsibility. Although, given the grave nature of a decision which will lead to the death of the child, where both parents are actively involved, in practice the treatment will continue until both agree that it is no longer in the best interests of the child or there is a decision of the court.<sup>89</sup> Where questions arise about the withholding or withdrawal of life-sustaining treatment from a child in the care of the state, it is vital that grave treatment decisions are either agreed by all with parental responsibility together with the child's doctors or by a court. This is necessary to protect the interests of a child vulnerable by virtue of his or her medical condition, the inability of his or her parents to care for and advocate for him or her and, with continued medical intervention, the prospect of life in intensive care or in the care of the state. There are limits to the local authority exercise of parental responsibility, where decisions about a child's medical treatment may result in the ending of his or her life, the local authority cannot act alone. The agreement of all with responsibility for the child or the decision of the court ensures that the decision is made according to a judgement of the best interests of the child, in cases of any doubt, publicly by an independent judge in a process in which the decision-maker can be held to account. The responsibility of the court is to ensure a process in which the interests of vulnerable children of vulnerable parents in the care of the state are properly protected.

### **Public Responsibilities for the Welfare of Children**

The final question is the relevance of this analysis to the recent high profile cases concerning Charlie Gard,<sup>90</sup> Isaiah Haastrup,<sup>91</sup> Alfie Evans<sup>92</sup> and Tafida Raqeeb.<sup>93</sup> None of these children were in the care of the local authority. In all cases, their parents had done all they could to ensure that their seriously ill child received the best possible treatment and care, had researched their child's condition and identified alternative care providers when those with responsibility for their child's clinical care had reached the view that there were no more treatment options which had a chance of improving the child's condition. In all cases, despite having reached a different conclusion to the doctors about their child's future care, the parents were seeking to do their very best for their child. The analogies drawn with child protection proceedings in submissions

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<sup>88</sup> *Re Jake* [2015] EWHC 2442, [44].

<sup>89</sup> As in *Re RB* [2010] 1 FLR 946 and although *An NHS Trust v SR* [2012] EWHC 3842 was concerned with the administration of conventional radiotherapy and chemotherapy, Bodey J observed that the doctors could have treated given the consent of the child's father but that he appreciated why the Trust had applied to court given the serious nature of the treatment at issue.

<sup>90</sup> The declarations made by Francis J, in *GOSH v Yates & Gard* [2017] EWHC 972, that it was in Charlie's best interests and lawful for him not to be provided with a trial of nucleoside therapy and for ventilation to be withdrawn and palliative care provided were upheld through the appeal courts.

<sup>91</sup> The declarations made by MacDonald J in *King's College NHS Trust v Thomas & Haastrup* [2018] EWHC 127 were upheld through the appeal courts.

<sup>92</sup> The declarations made by Hayden J in *Alder Hey Children's NHS Foundation Trust v Evans* [2018] EWHC 308 that it was in Alfie's best interests and lawful for ventilation to be withdrawn and palliative care provided were upheld by the appeal courts.

<sup>93</sup> *Tafida Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) & *Barts NHS Foundation Trust v Shalina Begum and Muhamed Raqeeb & Tafida Raqeeb* [2019] EWHC 2530 (Fam).

on appeal were made in the attempt to secure what they considered to be in the best interests of the child.<sup>94</sup> However, not only was the law applied in these cases founded in the cases considered above, but the public responsibility to ensure that the care the child received protected their welfare equally applied to limit parental freedom to pursue what they considered to be best for their child.

The legal framework applied by the judges of the Family Division, upheld by the Court of Appeal and Supreme Court had its foundations in the judgments of Heilbron J in *Re D*<sup>95</sup> and the House of Lords in *Re B*.<sup>96</sup> In each case, the judge applied a best interests analysis to determine the child's future medical treatment. The approach taken to determination of best interests was based in the judgments of Lord Donaldson MR in the 1990s cases of *J* in which he also held that neither parents nor the court could require doctors to administer treatment that is 'medically contra-indicated' or which they could not 'conscientiously administer'.<sup>97</sup> Although not stated in such terms given the focus upon determination of best interests, the evidence suggests that that was the position of the treating doctors in each of these cases and that their professional judgement was supported by second opinions and independent experts.<sup>98</sup>

The question raised by each of these cases was why should the parents of Charlie Gard, Isaiah Haastrup, Alfie Evans, and Tafida Raqeeb not be free to move their child to the care of another doctor willing to take responsibility for them when those currently responsible for the child's medical treatment had reached the view that there were no more treatment options available. In all cases the hospital had applied to court for a declaration that it would be lawful, as in the child's best interests, to withdraw life-sustaining ventilation and to provide palliative care. Charlie's parents wanted him to receive innovative nucleoside bypass therapy which, at the time legal proceedings were commenced, was being offered by an expert in the US but which his medical team considered, because of the extent of the damage to his brain, no longer offered him any chance of improvement. Isaiah's parents wanted his life to be sustained on ventilation. Alfie's parents wanted him to be transferred to Italy, where doctors were prepared to offer long term ventilation or to Germany where a doctor was willing to undertake a tracheostomy and gastrostomy with the aim of enabling to home ventilation. Tafida's parents also wanted her to be transferred to Italy where doctors were prepared to continue ventilation, taking more time to determine whether she could be provided with home ventilation. However, with the exception of Tafida, in all of these cases it was the unanimous view of the treating team, supported by independent experts and second opinions, that there were no further treatment options available which could improve the child's condition and, consequently, continued ventilation would mean that the children would live the remainder of their life kept alive in intensive care and, due to their condition, without the ability to benefit from interaction with those who cared for them.

Ordinarily, decisions about a child's medical treatment are private decisions, reached by parents working in partnership with the treatment team to agree upon the treatment

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<sup>94</sup> Explored, for example in, Goold I, Herring J and Auckland C(eds), *Parental Rights, Best Interests and Significant Harms: Medical Decision-Making on Behalf of Children Post-Great Ormond Street Hospital v Gard* (Hart, 2019).

<sup>95</sup> *Re D* [1976] Fam 185.

<sup>96</sup> *Re B* [1981] 1 WLR 1421.

<sup>97</sup> *Re J* [1991] Fam 33, *Re J* [1993] Fam 15.

<sup>98</sup> As argued in Jo Bridgeman, 'Beyond Best Interests: A Question of Professional Conscience?' in *Parental Rights, Best Interests and Significant Harms: Medical Decision-Making on Behalf of Children Post-Great Ormond Street Hospital v Gard*, Imogen Goold, Jonathan Herring and Cressida Auckland (eds), Hart, 2019, 137-152.

plan that is in the best interests of the child. The welfare of the child is protected by the agreed, or at least accepted, determination of best interests by those primarily responsible for the care of the child, his or her parents and treating team. However, it is because parental responsibility to determine the best interests of the child co-exists with the legal duties of doctors to children that when doctors are not able, in the exercise of their professional judgement and in accordance with their professional conscience, to treat according to the wishes of parents, the dispute must be referred to court. The responsibility of the judge is then to decide the course of action that is in the welfare of the child on the evidence presented to the court. There are limits on the freedom of parents to make decisions about the medical treatment of their child when the doctors with legal duties cannot accede to their preferences framed by, as MacDonald J has put it, the Trust's 'safeguarding obligations in relation children who are not deriving benefit from life sustaining treatment'.<sup>99</sup> The parents, families, and supporters of Charlie, Isaiah, and Alfie felt strongly that the doctors and the judge reached the wrong conclusion. However, the evidence before the court that there was no prospect of any improvement, that the child could not experience the love, care, and attention given to them and that the prospect for their future was to be kept alive through invasive interventions on an intensive care ward. Taken together this led to the conclusion that it was not in the child's interests for life-sustaining intervention to continue.

The public policy requirement to bring a dispute between parents and doctors over a child's medical treatment before a court was recently addressed by MacDonald J in the case of *Tafida Raqeeb*. In the context of a dispute between her parents and treating doctors, and equally applicable I argue in relation to children without a relational advocate, MacDonald J identified these as, the public interest in the protection of a child's best interests as one of the fundamental interests of society, ensuring that a child has an independent voice when those most directly involved disagree and securing the equal treatment of all children in such cases.<sup>100</sup> His Lordship also explained that determination by the court ensures that the welfare and rights of the child are protected, that parental decisions are subjected to scrutiny and that professionals can fulfil their legal and professional duties to children in their care in fulfilment of their duties of care and under s.11(2)(a) of the Children Act 2004.<sup>101</sup> The decision to give *Tafida's* parents permission to transfer her to Genoa to allow more time to ascertain whether she would regain her capacities was based upon evidence from a responsible body of medical opinion that she should be maintained on life support 'with a view to placing her in a position where she can be cared for at home on ventilation by a loving and dedicated family in the same manner in which a number of children in a similar situation to *Tafida* are treated in this jurisdiction'.<sup>102</sup> The evidence before the court was therefore that the treatment which her parents wanted her to receive was supported by a responsible body of professional opinion so that the parental determination of her best interests was supported by professional judgement about her welfare. This was determined in legal proceedings when her treating doctors

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<sup>99</sup> *Tafida Raqeeb (by her Litigation Friend) v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) & *Barts NHS Foundation Trust v Shalina Begum and Muhamed Raqeeb & Tafida Raqeeb (by her Children's Guardian)* [2019] EWHC 2530 (Fam), [56].

<sup>100</sup> *Tafida Raqeeb (by her Litigation Friend) v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) & *Barts NHS Foundation Trust v Shalina Begum and Muhamed Raqeeb & Tafida Raqeeb (by her Children's Guardian)* [2019] EWHC 2530 (Fam), [151].

<sup>101</sup> *Tafida Raqeeb (by her Litigation Friend) v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) & *Barts NHS Foundation Trust v Shalina Begum and Muhamed Raqeeb & Tafida Raqeeb (by her Children's Guardian)* [2019] EWHC 2530 (Fam), [55].

<sup>102</sup> *Tafida Raqeeb (by her Litigation Friend) v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) & *Barts NHS Foundation Trust v Shalina Begum and Muhamed Raqeeb & Tafida Raqeeb (by her Children's Guardian)* [2019] EWHC 2530 (Fam), [186].

had reached the conclusion that continued ventilation was not in her interests. State intervention, through the courts, ensured that Tafida's best interests were protected.

Lord Sumption, in his 2019 Reith Lectures,<sup>103</sup> expressed the view that Charlie Gard's case would not have reached the courts a generation ago. A generation ago, the case may have been seen as one of parental authority and right to determine the future medical treatment of their child. A generation ago, Charlie's case may have been formative of the principles governing the provision of medical treatment to children rather than an unsuccessful challenge to established principles. I respectfully disagree with Lord Sumption's characterisation of the case as a troubling example of Law's Expanding Empire into the domain of the private. I argue that the case demonstrates that there are public, as well as a parental and professional, responsibilities for the welfare of children, including those whose parents are desperately seeking to do what they consider to be best for them. Cases concerned with a child's medical treatment are not only concerned with the best interests of the child, they are also concerned with fundamental questions about the public responsibilities for the care and protection of children.

Public responsibility, through local authority responsibilities, was formative in the early cases and continues to be important today in cases concerning vulnerable children in the care of the state who do not have parents advocating for them as did Charlie, Isasiah, Alfie, and Tafida. The shared responsibility for support, protection, and care means that the court has an important function in the determination of grave issues affecting the lives of vulnerable children in local authority care ensuring that their welfare is protected and decisions can be subjected to scrutiny and debate. And, when those with parental responsibility and professional duties cannot agree on the best interests of the child, those same shared responsibilities justify public intervention in family life. Parental responsibilities are constrained by professional duties and public responsibilities to protect the welfare of children.

January 2021

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<sup>103</sup> Lord Sumption, *Law's Expanding Empire*, Reith Lectures 2019, BBC Radio 4.